# Medicare Supplement

NOTE: These standards are provided to assist the insurer in filing forms and rates. They are not intended to be all-inclusive, and are a work in progress. References beginning with "31A" refer to the insurance code as part of Utah Code Annotated (U.C.A.) and those beginning with "R590" refer to department rules as part of the Utah Administrative Code (U.A.C.). The comments are a brief synopsis of the referenced material and do not contain all requirements or exceptions. All references should be reviewed for compliance. As required by U.C.A. § 31A-21-201(2), *the insurer is responsible* for assuring that forms and rates submitted comply with Utah Insurance Code and Rules.

| General Requirements | | |
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| Application | 31A-21-201(3) | Questions used to elicit health condition information may not be vague and must reference a reasonable time frame in relation to the health condition. |
| Arbitration | R590-122<br>Bulletin 96-9 | An arbitration provision must be properly disclosed in the policy, certificate, application and enrollment forms. It may not deprive Utah courts of jurisdiction over an action against an insurer, except as provided in permissible arbitration provisions. |
| Certificate Disclosure | 31A-21-311 | The certificate shall contain a summary of the essential features of the insurance coverage, including any rights of conversion. |
| Claim Settlement | 31A-26-303<br>R590-192 | Provides for fair and rapid settlement of claims and protection of claimants from unfair claims settlement practices. |
| Company Name | 31A-21-201 & 301(1) | The exact name of the insurer and its state of domicile must appear conspicuously in the policy. |
| Discretionary Authority | R590-218 | This rule prohibits the use of reservation of discretion clauses in forms that are not associated with ERISA employee benefit plans. It creates a safe harbor for insurance companies that provide insurance to ERISA employee benefit plans sponsored by employers, allowing insurers to know what language in insurance forms is acceptable to the department. |
| Examination Period | 31A-22-620(6)<br>R590-146-17(5) | The applicant has the right to return the policy or certificate with 30 days of its delivery and to have the premium refunded. |
| Felony, riot or insurrection | 31A-21-201 | May exclude losses resulting from an insureds participation in a felony, riot or insurrection, or similar acts only if the insured is an active participant. |
| Filing of Forms | 31A-21-201<br>Bulletin 99-2 | Forms are accepted on a file and use basis. It's the insurers responsibility that the filing is incompliance with Utah Code and Rules. |
| Grace Period | 31A-22-607 | Policies shall provide a grace period, during which the policy must continue in force. |
| Incontestability | 31A-22-609 | Only a fraudulent misstatement regarding insurability is a basis for avoidance after coverage has been in effect for two years. |
| Incorporation by Reference | 31A-21-106<br>Bulletin 96-9 | Except as provided in 31A-21-106(1)(b), no policy may contain any agreement or incorporate any provision not fully set forth in the policy, application, or attached documents. |
| Limitation of Actions | 31A-21-313 & 314 | Such provisions cannot restrict the right of action against an insurer to no less than 60 days and no more than three years from the date the cause of action accrues. In addition, they may not deny Utah court jurisdictions. |
| Nondiscrimination Among Health Care Professionals | 31A-22-618 | No insurer may unfairly discriminate against any licensed class of health care providers. |
| Proof of Loss and Notice | 31A-21-312<br>Bulletin 87-6 | Proof of loss provision must allow the insured or claimant to file the notice and /or proof of loss as soon as reasonably possible. Failure to give any notice or file any proof of loss required by the policy within the time specified in the policy does not invalidate a claim made by the insured, if the insured shows that it was not reasonably possible to file the notice or proof of loss within the specified time and that notice was given or proof of loss was filed as soon as reasonably possible. Failure to give notice or file proof of loss does not bar recovery under the policy if the insurer fails to show it was prejudiced by the failure. |
| Sample Data | R590-86<br>Bulletin 99-2 | Each form must be completed with data that is representative of the market intended to accurately reflect its purpose and use. |
| War, acts of war | 31A-21-201 | May exclude losses resulting from war, acts of war declared or undeclared, and terrorism. Nuclear, biological and chemical release losses may also be excluded if a direct result of war, acts of war, or terrorism. |
| Variability | Bulletin 99-2 | All variable information must be bracketed with an explanation of the variables. Changes must be refilled prior to use. |
| **Specific Requirements**<br>**Note - The Utah Insurance Department has adopted the NAIC model regulation for Medicare Supplement** | | |
| Advertising | 31A-22-620(7)<br>R590-146-19 | Medicare supplement advertisement must be filed prior to use. |
| Application Forms and Replacement Notice | R590-146-18 | Requirements for application forms and replacement coverage. |
| Benefit Limits | R590-146-8.A(2) | A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. |
| Claim Payment | R590-146-13 | Standards for claims payment. |
| Definitions | R590-126 & 146 | Definitions in the forms may not exceed the definitions in these rules. A definition in Rule R590-146 will supercede a definition that also appears in Rule R590-126. |
| Duplicative Benefits | R590-146-6.C. | No Medicare supplement policy or certificate shall contain benefits that duplicate benefits provided by Medicare. |
| Exclusionary Riders | R590-146-6.B. | No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. |
| First Page Disclosures | R590-146-17 | The first page shall include a renewal or continuation provision, and the right to change premiums and any automatic renewal premium increases based on age. |

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| Outline of Coverage | R590-146-17 | Standards for outline of coverage and acknowledgement requirements. |
| Policy Exclusions | R590-146-6.A, B, & C | Except for permitted preexisting condition clauses, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare. |
| Preexisting condition | R590-146-8.A.1 | A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage for a preexisting condition. A preexisting condition shall not be defined more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage. |
| Renewability | R590-146-8.A(5) | Each Medicare supplement policy shall be guaranteed renewable. It may not be cancelled or non-renewed for any reason other than nonpayment of premium or material misrepresentation. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subsection 8A(5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy. |
| Replacement Provisions | R590-146-23 | If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy. |
| Riders or Endorsements | R590-146-17 | Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, shall require a signed acceptance by the insured.<br><br>Any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law.<br><br>Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy. |
| Spouse Termination | R590-146-8.A.4 & 5 | No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium. |
| Standardized Plans | R590-146-9 | Each issuer must make available a policy or certificate that includes the basic "core" package of benefits to each prospective insured. An issuer may make available any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it. Benefit plans shall be uniform in structure; language, designation and format to the standard benefit plans "A" through "J." |
| **Medicare Select Requirements** | | |
| Medicare Select Requirements | R590-146-10 | No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section. Medicare Select Plans are required to comply with all sections of R590-146, not just section 10. |
| Plan of Operation | R590-146-10.D, E and F | A Medicare Select policy may not be issued until the issuers Plan of Operation is filed and approved by the Commissioner. The filing must contain at least the information required in R590-146-10.E. Any proposed change, except for network providers, must also be filed. |
| Opportunity for Other Medicare Products | R590-146-10.N | Issuers shall make available the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision, if available. The issuer shall make the policies and certificates available without requiring evidence of insurability. |
| **Rating Requirements** | | |
| Content Requirements | R590-146-14.A<br>R590-85 | All information required in the rule and its appendix must be submitted with both an initial rate filing and a rate revision. |
| Loss Ratio Standards | R590-146-14.A(1) | Individual policies must meet a lifetime loss ratio of at least 65%, and an expected third-year loss ratio of at least 65%. Group policies must meet the same standards at 75%. |
| Premium Rates | 31A-22-602 and 620(4) | Premiums must be reasonable relative to benefits. |
| Rate Availability | Federal Bulletin 01-01 | An issuer may not differentiate between a preferred rate and a standard rate for applicants applying under their guaranteed issuance rights. The lowest available rate must be used. |
| Rate Revision Effective Date | R590-146-15.B. | The insurer may not revise their rates until they receive the "Rates Filed" stamp from the department. The effective date of the revision must be at a date later than the date indicated on the stamp. |
| Submission of Rates | R590-85-3<br>R590-86-3.B<br>Bulletin 99-2 | When filing a new individual policy, the rate and its supporting documentation must be included. |
| **Reporting Requirements** | | |
| Annual Filing of Premium Rates | R590-146-14.C. and Bulletin 99-2 | This report is due May 31 each year. Bulletin 99-2 currently states it is due March 1, it will be changed upon revision of the Bulletin. The filing MAY NOT contain a request for an increase. Refer to the NAIC Medicare Supplement manual for a checklist on all information that is required. |
| Benchmark / Refund | R590-146-14.B. | This filing is due May 31 each year. Copies of the forms are available on our web cite. |

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| Calculation Report | | |
| Grievances | R590-146-10.K(6) | Due March 31 each year. Issuers shall file the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances. |
| Multiple Policy Report | R590-146-22 | March 1 if each year an issuer must submit this report. The report is due even though the response is “NONE.” A format of the report is available on our web cite. |